Supreme Court, U.S.
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In The

Supreme Court of the United States

FRANCES CLAY,

Petitioner,

versus

PROCTER & GAMBLE PAPER PRODUCTS COMPANY, PROCTER & GAMBLE, and Certain Subsidiaries, PROCTER & GAMBLE DISABILITY BENEFIT PLAN, PROCTER & GAMBLE BENEFIT PLAN TRUST,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Whether federal courts have an obligation to review a benefit plan administered pursuant to the provisions of the Employee Retirement Income Security Act to determine if the Plan's provisions may reasonably be understood by plan participants?

Whether federal courts have an obligation to review a Plan administration claims procedure to determine whether a participant received the statutory notice required under 29 U.S.C. § 1133 and 29 C.F.R. § 2560.503-1(f)?

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OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1-11) is unreported. The opinion of the district court (App.12-533) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on December 29, 2000. A timely petition for rehearing and suggestion for rehearing en banc was denied on September 4, 2002. This Court's jurisdiction rests on 28 U.S.C. § 1254(1) (1999).

STATUTORY PROVISIONS INVOLVED

29 U.S.C. § 1133 provides as follows:

> In accordance with regulations of the Secretary, every employee benefit plan shall –
>
> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
>
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 U.S.C. § 1022(a) provides as follows:

> A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 1024(b) of this title. The summary plan description shall include the information described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) of this section shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 1024(b)(1) of this title.

STATEMENT OF THE CASE

Introduction

Petitioner is Frances Clay ("Mrs. Clay"), a former employee of the Proctor and Gamble Company Paper Products Company, whose employees participated in a disability plan administered by the Proctor & Gamble Disability Benefit Plan ("the Plan"). Mrs. Clay was injured in several automobile accidents between 1986 and 1993. She applied for long term/total disability benefits under the Plan. Such benefits were initially granted to Frances Clay, and then changed to partial disability benefits. Mrs. Clay appealed such determination by the Trustees, and her various appeals were denied; however the Trustees never advised her of how she did not meet the definition of

total disability – a term which was unclear to participants by the terms of the Plan and Plan description. Even after being awarded a total disability determination by the Social Security Administration, the Trustees of the Plan refused Frances Clay's appeals; however, once again, Mrs. Clay was never advised in her denial notices of how she did not meet the definition of total disability or how she could perfect her claim – all in violation of ERISA.

Legal Standard Governing Review of the Record

The Court of Appeals affirmed a grant of summary judgment against Petitioners. When summary judgment is considered by a court, the record, including "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits" must be viewed in the light most favorable to Petitioners and all reasonable inferences must be drawn in their favor. Fed. R. Civ. Pro. 56(c), *Celotex Corp. v. Catrett*, 477 U.S. 317 (1986).

The Facts Giving Rise to This Case

Frances Willis Clay ("Mrs. Clay") is a former employee of the Proctor & Gamble Paper Products Company ("the Company" or "Proctor and Gamble") who worked for such employer for 15 years. Mrs. Clay and other Proctor & Gamble employees were eligible participants in the Proctor & Gamble Disability Plan ("the Plan") administered by the Trustees for the Plan ("the Trustees"). In 1986, Petitioner was injured when she was in an automobile struck by a drunk driver which resulted in her extended absence from work due to her injuries. Thereafter, unfortunately, Mrs. Clay was involved in three (3) other automobile accidents between 1988 and 1993, further exacerbating her

injuries and resulting in new injuries to her head, spine, and extremities. Dr. John Baker, Mrs. Clay's treating neurologist, issued a medical diagnosis that the Petitioner was limited in physical capabilities in that she was unable to work, except with the assistance of special equipment and in a controlled environment with accommodation of her various physical limitations. Following her injuries, Proctor & Gamble employed Petitioner as a store room clerk at its Albany facility, and, although Mrs. Clay found it very difficult to perform these duties, she worked through daily pain to maintain her position with the Company.

In November 1993, the Company advised Mrs. Clay that it was eliminating her position. Frances Clay learned that Proctor & Gamble requested an update of her condition, claiming that it needed to be informed of her physical limitations. Mrs. Clay provided a Proctor & Gamble Disability Plan Physician Certificate Form from her physician (Dr. Baker) dated December 21, 1993, which stated that she could not perform overhead lifting of more than 20 pounds, nor could she lift over 30 lbs., nor could she carry items weighing over 20 lbs, nor could she climb ladders, or engage in a full range of lifting (See Defendants' Statement of Material Facts [hereinafter "R.35,"] Exhibit 13).

The Company Plant Manager advised Mrs. Clay that no work was available to accommodate her restrictions (R.35, Exhibit 11). Mrs. Clay then brought to the Company a December 22, 1993 clarification from her physician regarding such restrictions (R.35, Exhibit 13, p. 2). The Company determined that there still was no work for the Petitioner. Mrs. Clay then applied for long term disability benefits under the Proctor & Gamble Disability Plan.

The Company advised Frances Clay that it was placing her on Plant Disability for one week. The Plan administrators then determined that Mrs. Clay should be placed on total disability. Thereafter, the Plan's Trustees notified Mrs. Clay that her status was being changed from total disability to partial disability *via* a January 25, 1994 letter addressed to an official of the Company, which was forwarded to Mrs. Clay (R.35, Exhibit 21). In such letter, the Trustees wrote that Mrs. Clay's physician stated that she could return to work with certain physical restrictions and that "As such, Mrs. Clay is partially disabled as that term is defined in Article II, Section II of the Plan." *(Id).*

The Plan defines Partial Disability as follows:

> " . . . a mental or physical condition resulting from an illness or injury because of which the participant cannot perform regular duties but can perform other useful duties. . . . " (R.35, Exhibit 1, p. 3)

The Plan goes on to provide:

> ". . . . Partial disability does not necessarily prevent the participant from performing useful tasks, utilizing public or private transportation, or taking part in social or business activities outside of the home." (R.35, Exhibit 1, p. 3)

The Plan does not define anywhere in its provisions what is meant by the term "useful tasks," nor are there any examples of "useful tasks" provided. (R.35, Exhibit 1).

The Plan's summary provided in the Proctor and Gamble Paper Products Employee Handbook states as follows:

> "You'll qualify as partially disabled if an off the job physical or mental illness or injury keeps you from performing your regular duties but doesn't keep you from performing other duties either for the company or another employer." (R.35, Exhibit 4, p. 16)

The Plan's definition of "total disability" is as follows:

> ". . . a mental or physical condition resulting from an illness or injury which is generally considered totally disabling by the medical profession. Total disability involves a condition of such severity as to require care in a hospital or restriction to the immediate confines of the home." (R.35, Exhibit 1, p. 5).

On March 9, 1994, Frances Clay appealed the Trustees' determination that she was partially disabled, instead of totally disabled. The Trustees responded *via* an April 12, 1994 letter to her as follows:

> "With your appeal you provided copies of medical reports from 1986 and 1994. The Trustees do not believe that this additional information supports your claim for total disability benefits. . . ." (R.31, Exhibit 21).

In this denial notice, the Trustees did not state what information was needed to support Mrs. Clay's claim for total disability benefits.

Following a series of exchanges between the Trustees, Company officials, the Petitioner, and her physician, the Trustees suspended Frances Clay's partial disability benefits; the Company advised her that she was terminated, and then the Plan Trustees restored such benefits once Mrs. Clay underwent a Functional Capacity Assessment, despite her

and her physician's statement regarding her inability to undergo such an exercise (R.35, Exhibits 25, 26, and 27). The Petitioner also applied for Social Security total disability benefits, pursuant to the instruction of the Trustees. She was initially denied such benefits by decision dated October 31, 1994.

On December 15, 1994, Frances Clay's attorney wrote to Proctor & Gamble requesting that it reconsider the denial of Petitioner's claim for long term disability (such benefits ended December 11, 1994). The Company's attorney responded by letter stating that the Trustees would make a determination, but that it was his understanding that the Plan would defer to any total disability determination by the Social Security Administration. (R.35, Exhibit 37).

In fact, the Plan was amended in 1996 to provide that it would generally defer to determinations made by the Social Security Administration if such determination came after the termination of partial disability benefits and after the sixty (60) day period to appeal such determinations. (R.35, Exhibit 37, p. 2).

The Petitioner's partial disability benefits, according to the Trustees, ended on December 11, 1994 (after a 52 week period). Following a letter/appeal from Frances Clay's attorney dated December 14, 1994, the Trustees wrote back to say that the information provided by her physician – which stated that she was totally disabled, and that it was indefinite as to when she could return to work, if ever – was insufficient. The Trustees' letter denying her appeal did not state what information or documentation the Petitioner could submit to successfully present her claim. (R.35, Exhibit 35).

Frances Clay continued to appeal the Social Security Administration determination, and on November 26, 1997, after a hearing before an Administrative Law Judge, she was determined to be totally disabled, and entitled to Social Security benefits retroactive to the date she initially applied for the same. (R.35, Exhibit 38, pp. 2-6). Based upon the Plan's provisions regarding its deferral to a Social Security Administration finding of total disability, by letter dated March 14, 1997, Mrs. Clay asked the Trustees to reconsider their denial of her claim for total disability. The Trustees responded by letter dated April 11, 1997 that the information provided by Frances Clay was insufficient to support her claim. The letter did not set forth what information would be deemed sufficient to support such a claim. (R.35, Exhibit 39).

Frances Clay submitted an appeal to the Trustees' decision dated April 11, 1997 by providing to the Plan administrators the decision of the Administrative Judge in her Social Security case. The Trustees responded by letter dated April 25, 1997 stating that this additional information was insufficient, but did not specify what information would be considered sufficient (R.35, Exhibit 41). In this particular denial notice, the Trustees also stated that the information submitted was untimely. Frances Clay then responded and submitted the Social Security Administration determination, as well as extensive medical documentation which supported the determination by that agency. The Trustees responded by letter dated July 9, 1997 stating that the additional information was not sufficient to alter its determination, and by also stating that the documentation submitted was untimely (R.35, Exhibit 43).

The District Court's Summary Judgment Order

The district court held that, since there was no conflict of interest, the standard for review of the Trustees' determinations that Mrs. Clay was not entitled to total disability benefits was under the deferential "abuse of discretion" standard. The court further held that the actions of the Trustee were not arbitrary and capricious.

The Eleventh Circuit Proceedings

The Eleventh Circuit affirmed the district court's decision in its entirety.

Under the terms of ERISA, a Plan description must be sufficiently accurate and comprehensive to reasonably apprise participants of their rights and obligations. Furthermore, under the provisions of 29 U.S.C. § 1133 and 29 C.F.R. § 2560.503(1)(f), Plan administrators must provide, in their denial of claims, notice of what provisions under the Plan the participant did not meet, and what additional information such participant may present to perfect her claim. Neither the district court nor the Court of Appeals addressed these issues pointed out by the Petitioner, which renders her federal court review deficient in accordance with the purposes of ERISA. A timely petition for rehearing and rehearing en banc was denied without comment. Petitioner requests that this Court grant the petition and summarily reverse the Eleventh Circuit's judgment, remanding Petitioner's ERISA claim for further proceedings.

REASONS FOR GRANTING THE WRIT

The Eleventh Circuit's Decision Conflicts with the Holdings of Four Other Federal Circuits and the Express Provisions of ERISA, and this Court Should Grant a Writ of Certiorari to Determine What the Responsibilities are for Federal Review of a Plan Administered Under the Provisions of ERISA, or Alternatively, the Decision of the Eleventh Circuit Should Be Summarily Reversed

The facts of this litigation are numerous; however, the pattern of what occurred is, unfortunately for the Petitioner, repetitive and straightforward. Frances Clay was injured in a series of automobile accidents which left her totally disabled as determined by her physician (R.35, Exhibit 4). EEG results show that she has brain abnormalities and permanent damage to her spine (R.35, Exhibit 10). All of this information was communicated to the Proctor & Gamble Disability Plan, and was determined to constitute total disability by the Social Security Administration.

Mrs. Clay was initially determined by the Plan Administrator to be entitled to total disability benefits. The Trustees then advised Mrs. Clay that they were changing their determination, and that she only qualified for partial disability benefits. Mrs. Clay immediately appealed this decision explaining that she was totally disabled. The Plan Trustees responded and told Clay that she was not totally disabled, but never explained to Frances Clay, the beneficiary, the specific reasons for their denial in a manner calculated to be understood by her, nor did the notice given to her by the Plan Trustees provide any reference to the plan provision(s) upon which the denial was based, nor did

the Plan Trustees provide a description of what additional information would be necessary for her claim to be perfected, nor did they provide steps to be taken to submit a claim for review – all in violation of the provisions of 29 U.S.C. § 1133 and 29 C.F.R. § 2560.503(1)(f). Instead, Mrs. Clay was forced to guess as to what documentation she could provide to the Plan Trustees to support her claim for total disability benefits. Such acts by the Trustees of a Plan are clearly arbitrary and capricious and a direct violation of ERISA. Additionally, the record clearly shows that the Proctor & Gamble Disability Plan itself was impossible to interpret to understand what definition was necessary to comply with to be deemed totally disabled. As such, since the Plan itself was totally devoid of a participant's ability to understand, coupled with the fact that the Plan Trustees never explained it to Mrs. Clay in any of its denial notices, the inescapable conclusion is that the Plan's administrators violated ERISA provisions in that 1) the Plan's provisions were confusing and were not for the exclusive benefit of the beneficiaries, and were in conflict with each other, and 2) the Trustees' notices and denials to Mrs. Clay were totally defective in that they did not provide to her any notice of how she did not meet the terms of the Plan, or provide to her notice of what additional information she needed to perfect her claim.

A. The Implementation of a Plan Which is Totally Ambiguous to the Participants is a Violation of ERISA

The Employee Retirement Income and Security Act was enacted by Congress to assure the fair administration of qualified plans for the benefit of its participants. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). To

that end, this Court has explained the purpose of ERISA protection as follows:

> ". . . ERISA, like LMRA, imposes a duty of loyalty on fiduciaries and plan administrators" and "ERISA was enacted 'to promote the interests of employees and beneficiaries in employee benefit plans,'" quoting *Shaw v. Delta Airlines*, 463 U.S. 85, 90 (1983), and "A fiduciary has authority to control and manage the operation and administration of the plan, 1102(a)(1), and must provide a 'full and fair review' of claim denials, 1133(2)."
>
> *Firestone, Id.*, at 112-113

An essential requirement of a plan governed by the provisions of ERISA is that its provisions and administration be for the exclusive benefit of the beneficiaries. *Balu v. Dale Monte Corporation*, 748 F.2d 1348 (9th Cir. 1984), certiorari denied at 474 U.S. 865 (1985). *Brown v. Retirement Committee of the Briggs & Stratton Retirement Plan*, 797 F.2d 521 (7th Cir. 1986), citing 29 U.S.C.§ 1104(1). The Proctor & Gamble Plan did not in any way clearly define what requirements a participant had to meet to be considered "totally disabled."

The Plan's summary provided in the Proctor & Gamble Paper Products Handbook explains partial disability as follows:

> "You'll qualify as partially disabled if an off the job physical or mental illness or injury keeps you from performing your regular duties but doesn't keep you from performing other duties either for the company or another employer." (R.35, Exhibit 4, p. 16)

Partial disability is defined as a condition which keeps a participant from performing her regular duties, but doesn't keep her from performing other duties either from the Company or another employer. The logical interpretation is that if one ***cannot*** perform "other duties" for the Company or another employer, the employee is considered to be totally disabled.

The Plan also defines partial disability as follows:

> " . . . a mental or physical condition resulting from an illness or injury because of which the participant cannot perform regular duties but can perform other useful duties. . . . " (R.35, Exhibit 1, p. 3)

The Plan goes on to provide:

> ". . . Partial disability does not necessarily prevent the participant from performing useful tasks, utilizing public or private transportation, or taking part in social or business activities outside of the home." (R.35, Exhibit 1, p. 3)

Again, the logical interpretation of this definition is that if a participant cannot perform "other useful duties," then such a participant is beyond partial disability and is entitled to total disability benefits. Neither "other duties" nor "useful duties" is defined under the Plan.

Mrs. Clay's neurologist sent medical statements to the Plan administrators on the Proctor & Gamble Disability Benefit Plan Physician Certificate form stating that she was totally disabled, and stating that he did not know when or if she could ever return to work. (R.35, Exhibit 42, No.8).

Total disability is defined under the Plan as follows:

> "... a mental or physical condition resulting from an illness or injury which is generally considered totally disabling by the medical profession. Total disability involves a condition of such severity as to require care in a hospital or restriction to the immediate confines of the home." (R.35, Exhibit 1, p. 5).

Mrs. Clay was considered totally disabled by her physician, who certified on the Plan's disability form that she had been hospitalized and/or was restricted to the immediate confines of the home. Additionally, Proctor and Gamble determined that her numerous restrictions were too limiting for any work there.

It is clear, therefore, that the terms of the Plan state that one may be considered totally disabled by the medical profession, but it is unclear as to whether one also has to be considered unable to perform "other duties" or "useful duties." As such, the Plan is confusing to its participants – for whose exclusive benefit it is to be administered – in direct violation of the provisions of ERISA. 29 U.S.C. § 1104(1). The district court failed to address the issue of the Plan's arbitrariness in its opinion, and the Court of Appeals failed to correct this omission of the district court in its opinion affirming the district court's decision. The Court of Appeals and the district court, therefore, committed harmful error which this court should reverse summarily or accept the Petitioner's writ regarding.

It is very evident that the language of the Plan is inconsistent, and further, that the provisions of the Plan and Plan summary provide various interpretations of what is required for a Plan participant to be considered totally

disabled. Although the Plan itself provides that the Trustees have authority to interpret the same, it is altogether unreasonable and an abuse of power and discretion for such Trustees to never explain to a Plan participant which interpretation it is utilizing to deny her benefits. In this instance, the Trustees told Mrs. Clay that she was considered partially disabled, but never advised her of which provisions of the various total disability definitions she not comport.

With regard to the definitions of partial disability, and more accurately, what the Plan states that partial disability is (and conversely, if one's condition goes beyond what is defined as partial disability, what then constitutes total disability), it has been held that a fiduciary's interpretation of the Plan much be reasonable. *Baxter v. Lynn,* 886 F.2d 182 (8th Cir. 1989), *DeNobel v. Vitro Corp.*, 885 F.2d 1180 (4th Cir. 1989).

It has also been held, however, that there are five factors to consider when determining whether a fiduciary's interpretation of the Plan is unreasonable: to wit – the following: 1) whether the interpretation is consistent with the Plan's goals, 2) whether the interpretation renders any Plan language meaningless or internally inconsistent, 3) whether the interpretation conflicts with the substantive or procedural requirements of ERISA, 4) whether the Board has consistently interpreted the words at issue, and 5) whether the interpretation is contrary to the clear language of the Plan. *Finley v. Special Agents Mut. Benefits Ass'n*, 957 F.2d 617, 621 (8th Cir. 1992).

In this instance, the Trustees did not state whether Mrs. Clay's condition was not considered totally disabled by the medical profession, whether she did not meet the

hospital confinement provision, whether she did not meet the confinement to her immediate home provision, or whether, applying other parts of the Plan Summary, they found that she could perform "other duties," or "useful duties."

The district court's opinion held that the Trustees' construction of the Plan, and their decision to deny Mrs. Clay's total disability benefits, was reasonable, but offers no indication of what the Trustees' interpretation of the Plan was and how it was reasonable. This is precisely what occurred in a similar fact scenario wherein the Eighth Circuit Court of Appeals held that the failure of the district court to articulate what its conclusion (that the Trustees actions were reasonable was based upon) was reversible error. *Brumm v. Bert B-11 NFL Retirement Plan*, 995 F.2d 1433 (8th Cir. 1993).

The fact that the Plan itself is altogether unclear and inconsistent with the Plan Summary Description renders such Plan to be arbitrary and capricous as a violation of ERISA. Under the statutory scheme of ERISA, it is required that a plan description "shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C. § 1022(a). The Proctor & Gamble Disability Plan did not reasonably apprise participants and beneficiaries of their rights and obligations. As set forth above, the Plan does not state whether, if one cannot perform useful or other tasks, one is considered to be totally disabled, since by the definition of partial disability, an individual should be able to perform these functions. Nor are "useful duties" and "other duties" defined in the Plan. In her opposition to the Defendants' Motion for Summary Judgment, the Petitioner pointed out

to the district court that the Trustees violated their fiduciary duties of administration required under ERISA. The district court, and the Court of Appeals, failed to address the issue of whether the Proctor & Gamble Disability Plan was sufficiently accurate and comprehensive to reasonably apprise participants of their rights and obligations under the Plan, and, therefore, the district court's granting of summary judgment in favor of the defendants should be reversed.

B. The Trustees Violated ERISA by Failing to Advise Frances Clay of How She Failed to Comply With the Plan or How She Could Perfect Her Claim

A basic requirement of ERISA is that the claims procedure of the benefits plan must adhere to the following minimum standards:

> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
>
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.
>
> 29 U.S.C. § 1133

More specifically, the regulations require that notice of denial of a claim adhere to the following:

(1) provide the specific reason for the denial, (2) provide specific reference to pertinent plan provisions on which the denial is based, (3) provide a description of any additional material or information necessary for the claim to be perfected and an explanation of why such material or information is necessary, and (4) provide information as to steps to be taken to submit a claim for review. 29 C.F.R. § 2560.503(1)(f).

A chronology of the Plan's denials of Frances Clay's appeal can be summarized as follows: 1) a January 25, 1994 decision to change the Petitioner's benefits from total to partial disability, 2) an April 12, 1994 denial of Frances Clay's appeal, 3) a January 10, 1995 denial of a second appeal filed on Petitioner's behalf, 4) an April 11, 1997 denial of a new claim by Petitioner for total disability benefits, considering her recent award of total disability by the Social Security Administration, 5) an April 25, 1997 denial of Mrs. Clay's appeal of the April 11, 1997 denial, and 6) a final July 9, 1997 denial of Frances Clay's last appeal.

In none of the Trustees' notices of denial of Frances Clay's claims do they advise her of 1) how the information she provided failed to comply with specific terms of the Plan, or 2) what specific information she would need to provide to adequately support her claim of entitlement to disability benefits. For instance, the initial denial letter to Mrs. Clay states as follows:

> "With your appeal you provided copies of medical reports from 1986 and 1994. The trustees do not believe that this additional medical information supports your claim for total disability benefits. The Trustees based their decision to change your status to partially disabled on the information

> contained in the physician's certificate signed by Dr. Baker on December 22, 1993." (R.35, Exhibit 21, p. 2).

No explanation is given as to how Frances Clay did not meet the requirements of the total disability definition. This is crucial because on December 12, 1996 the Petitioner's physician filled out a Proctor & Gamble Disability Physician's Certificate stating that Frances Clay was totally disabled as of December 14, 1993 (R.35, Exhibit 42, No.4).

The next denial letter came after Frances Clay appealed the April 12, 1994 decision of the Trustees. In the Trustees' January 10, 1995 denial letter (which came less than thirty (30) days after Mrs. Clay's partial disability benefits expired), the Trustees stated as follows:

> "The information provided in your appeal included an updated Physician's Certificate stating that as of December 2, 1994, it is 'indefinite when will return to work, if ever.' The newly submitted information does not provide any additional supporting medical information."
>
> (R.35, Exhibit 35)

The denial letter goes on to repeat the definition from the Plan as to what constitutes "Partial Disability," but ***the denial decision does not tell Mrs. Clay what provisions of the total disability requirements she failed to meet.*** The denial letter also states that "The Trustees requested that Mrs. Clay supply information from her Physician identifying any physical limitations supporting a finding of total disability;" however, a review of the Trustees' letter to Mrs. Clay confirms that at no point did such Trustees make

such a request to her. Furthermore, Frances Clay's physician filled out a Proctor & Gamble Disability Benefit Plan Physician's Certificate, completing every portion of such form (created by the Plan administrators for its disability determinations). In such Physician's Certificate submitted to the Trustees on Mrs. Clay's behalf, her physician stated that she was totally disabled as of 12/4/93, certifying also that she required a hospital stay or was confined to her home. The January 10, 1995 denial letter does not state how the information submitted by Mrs. Clay's physician, on a Proctor & Gamble Disability Plan Physician's Certificate form supplied by the Plan administrators for disability determinations, did not meet the requirements of total disability.

Mrs. Clay submitted a new claim on March 14, 1997 after receiving a retroactive determination of total disability status from the Social Security Administration.[1] This claim was denied by a letter from the Trustees dated April 11, 1997. The denial letter stated, in summary fashion as follows:

> "The Trustees have determined that no new medical information regarding your Physician restrictions was included and have determined that your partial disability status under the Disability Benefit Plan (Plan) is proper. The basis for the total disability award by the Social Security Award [sic] may differ from the terms of the Plan. Your disability status has been determined

[1] The Plan allowed for a review of a denial of benefits if the Social Security Administration made an award of total disability after the Trustees' denial of a total disability claim.

to be Partially Disabled under the Disability Benefit Plan effective December 14, 1993. Your appeal is denied."

(R.35, Exhibit 39)

Strikingly, the above referenced denial does not state how Frances Clay's appeal of March 14, 1997 failed to meet the criteria of total disability determination, nor does it state what additional information she could supply to perfect her claim.

Without understanding what the Plan Trustees required from her, or how she failed to meet the definition of total disability, Frances Clay used her best efforts to respond to the Trustees' denial letter and to support her claim. She, therefore, next sent a copy of the Social Security Administrative Law Judge's decision which explained the basis for that Agency's determination that she was disabled. On April 25, 1997, the Trustees sent to Mrs. Clay a denial of that appeal. In this denial letter, the Trustees stated to Mrs. Clay that "Although the summary of the medical information reviewed by the Social Security Administration appears to include new information, the summary of the medical information is insufficient." The Trustees' letter goes on to state that this new medical information should have been included in her December 15, 1994 appeal, and further states that Mrs. Clay did not provide medical information to support a finding of total disability (R.35, Exhibit 41). Once again, the Trustees failed to tell Frances Clay what provisions of the total disability definition she did not meet, and what specific additional information they needed such that she could successfully present a claim. Lastly, the Trustees arbitrarily decided that the information which Mrs. Clay presented was untimely, considering the fact that under the

Plan's 1996 Amendment, an award of total disability status by the Social Security Administration requires that the Trustees " . . . must review the medical information relied on in the Social Security Award of Total Disability." (R.35, Exhibit 37, "Background").

It has been held that the provisions of ERISA which require that claim notices contain certain information are critical to the enforcement of the statute's purposes. *Wolfe v. J.C. Penney Co.*, 710 F.2d 388, 392 (7th Cir. 1983), *University Hospitals of Cleveland v. Emerson Electric Co.*, 202 F.3d 839 (6th Cir. 2000). As stated by the Seventh Circuit Court of Appeals, providing this information in a fiduciary's denial notice is critical because such notice "enables a participant both to appreciate the fatal inadequacy of his claim as it stands and to gain a meaningful review by knowing with what to supplement the record." *Wolfe, Id.* at 392.

The Eighth Circuit Court of Appeals articulated the importance of the substantive notice requirements by stating that fiduciaries must comply with the ERISA requirements so that 1) applicants may clarify their application on appeal, and 2) federal courts may exercise an informed and meaningful review of the decision. *Dumond v. Centex Corp.*, 172 F.3d 618, 622 (8th Cir. 1999).

The Ninth Circuit has held that it is an abuse of discretion for a plan administrator to render a decision to a participant without sufficient explanation. *Bendixen v. Standard Insurance Co.*, 945 F.2d 276, 279 (9th Cir. 1991). See also *Young v. Secretary*, 975 F.2d 386, 393 (7th Cir. 1992), holding that the reason for rejecting the claimant's submissions must be articulated for there to be meaningful appellate review.

In the instant case, both the district court and the Court of Appeals set forth what was considered by such courts to be evidence that the Plan Trustees' determination that Frances Clay was not totally disabled was not an arbitrary and capricious decision; however, neither the district court, nor the Court of Appeals addressed the issue of the inadequacy of the Trustees' notices to Frances Clay regarding the denial of her claims. For instance, the district court goes to great discussion of the Trustees' reasonable reliance upon Mrs. Clay's physician's December 21 and 22, 1993 reports to Proctor & Gamble, and the results of a Functional Capacity Assessment completed on behalf of Proctor & Gamble. Similarly, the Court of Appeals refers to what it deemed to be acts and facts which rendered the decision of the Trustees to be reasonable in determining that Mrs. Clay was partially disabled. The following are excerpts from the decision of the Court of Appeals which show a reliance on the alleged acts of Frances Clay, rather than any appellate review of the Plan or the notices provided by the Trustees denying such claims:

> "Clay submitted a certificate from her physician that included the conclusory statement that she was totally disabled; it offered no supporting documentation for that conclusion. The Trustees of the Benefit Plan denied Clay's appeal of the partial disability determination." (App. p. 5)

and,

> "But even if ambiguity has been shown, it is undisputed that the Trustees were entrusted with discretion to interpret the Benefit Plan. . . . we will 'reverse the denial of benefits only if the denial is completely unreasonable.'" (App. 8-9); and

> "We conclude, as did the district court, that Clay raised no material issue on the reasonableness of the Trustees' determination of her claims given the medical evidence before them." (App. p. 9)

Nowhere in the Court of Appeals decision does the Court address the issue of whether the denial notices submitted to Mrs. Clay complied with the requirements under ERISA. Similarly, neither the district court nor the Court of Appeals reviewed the Plan or the Plan Summary to determine if the definition of total disability reasonably apprises participants and beneficiaries of their rights and obligations under the Plan, as required under 29 U.S.C. § 1022(a)(1).

The Petitioner argued to the district court in her response to the Defendants' Motion for Summary Judgment that among the Legal Issues was the following:

> "1. Whether Defendants breached their fiduciary duties concerning plan administration."
>
> (Plaintiff's Response to Defendants Motion for Summary Judgment, p. 2)

Mrs. Clay goes on to state, in her "Argument and Citation of Authority" portion of her response to the Defendants' Motion for Summary Judgment, that the Trustees were obligated to include specific information under the Act [ERISA] as follows:

> (1) The specific reason or reasons for the denial
>
> (2) Specific reference to pertinent Plan provisions on which the denial is based
>
> (3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why

such material or information is necessary, and

(4) Appropriate informationas [sic] to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.

- (Plaintiff's Response to Defendants' Motion for Summary Judgment, p. 3)

Similarly, the Petitioner presented these issues to the Court of Appeals in her appellate brief arguing as follows:

"The foregoing notification fails to advise the plaintiff as to why the information she provided was not sufficient to support a total disability claim, nor does it advise the plaintiff of WHAT INFORMATION SHE COULD PROVIDE that would be deemed a perfection of her claim and why. Similarly, the subsequent denial letters provided by the Plan to the plaintiff failed to advise her of what additional information was needed to perfect her claim (and why), but instead repeatedly advised her that the information that she provided was insufficient. This herein described 'hide and seek' placed the plaintiff at a distinct disadvantage, and resulted in her having to speculate as to what information would be satisfactory to the trustees, and prevented her from (1) knowing what information she needed to provide, and (2) being able to timely seek to obtain and present such information as a part of her claim."

(Appellant's brief p. 20)

The failure of both the trial court and the Court of Appeals to address the deficiency of the Trustees' claim denial notices was a critical deficiency which denied to

Frances Clay the right of full appellate review. If the ERISA notice requirements are to have any meaning, federal courts must review such notices and determine whether they are in adherence with the Act's requirements. To that end, it has been consistently held that one of the reasons for these specific notification requirements is so " . . . federal courts may exercise an informed and meaningful review of the pension boards' decision." *Skretvedt v. E.I. Dupont*, 268 F.3d 167 (3d Cir. 2001); *Dumond v. Centex Corp., Id.*, at 622. The fact that the Trustees did not follow the ERISA notice procedures, failed to provide Mrs. Clay with information on what part of the Plan she did not qualify under, and failed to advise her of what additional information she could provide to perfect her appeal, along with the fact that neither the district court, nor the court of appeals addressed these notification deficiencies despite the Petitioner's arguments before such courts, renders enforcement of ERISA meaningless for participants like Frances Clay. For the above and foregoing reasons, the decision of the Court of Appeals should be reversed, or this Court should accept the Petitioner's writ of certiorari.

CONCLUSION

The district court and the Court of Appeals failed to fulfill their obligation of appellate review, by failing to consider whether the terms of the Plan itself were sufficiently accurate and comprehensive to reasonably apprise participants of their rights and obligations, and by failing to review and address whether the Trustees violated ERISA by failing to provide to the Petitioner notice in their claim denials of what provisions of the Plan she did

not meet, or what additional information she could provide to perfect her claim, thereby committing reversible error.

For the above and forgoing reasons, the decision of the district court granting to the Defendant's Motion for Summary Judgment and the Court of Appeals' decision affirming such decision should be summarily reversed, or should be cause for this Court to grant a writ of ceritorari.

Respectfully submitted,

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[DO NOT PUBLISH]

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 00-11364
Non-Argument Calendar

D. C. Docket No. 98-01735-CV-JEC-1

FRANCES CLAY,

Plaintiff-Appellant,

versus

PROCTER & GAMBLE PAPER PRODUCTS COMPANY,
PROCTER & GAMBLE, and Certain Subsidiaries,
PROCTER & GAMBLE DISABILITY BENEFIT PLAN,
PROCTER & GAMBLE BENEFIT PLAN TRUST,

Defendants-Appellees.

Appeal from the United States District Court
for the Northern District of Georgia

(Filed Dec. 29, 2000)

Before EDMONDSON, BLACK and MARCUS, Circuit Judges.

PER CURIAM:

Plaintiff-Appellant Frances Clay appeals the grant of summary judgment dismissing her Employment Retirement Income Security Act ("ERISA") claims against Defendants-Appellants The Procter & Gamble Paper Products Company ("P&G Paper"), The Procter & Gamble

Company and certain subsidiaries, The Procter & Gamble Disability Benefit Plan (the "Benefit Plan"), and the Procter & Gamble Benefit Plan Trust. No reversible error has been shown; we affirm.

The facts are set out in the district court's comprehensive order. In short, Clay was employed by P&G Paper in 1978 and participated in the employee funded Benefit Plan. Between 1986 and 1993, Clay was involved in four automobile accidents. Beginning in 1987, because of medical restrictions imposed by her doctor, Clay was assigned to a position that entailed little physical or mental strain. Clay performed this position adequately until August 1993 when P&G Paper reorganized and eliminated Clay's position. Clay was asked to provide current medical documentation so that P&G Paper could find her another position consistent with her medical limitations. Clay supplied P&G Paper with a medical restriction form dated 21 December 1993 that limited Clay's lifting carrying and climbing activities. No jobs were available consistent with these limitations. The following day Clay supplied another medical assessment that modified the restrictions somewhat; nonetheless, no jobs were available consistent with the revised restrictions. Based on these medical assessments, the Benefit Plan granted Clay partial disability benefits.

P&G Paper medical staff referred Clay to an independent medical examiner on 12 January 1994. The referral was made because her doctor had prepared different assessments of her abilities on 21 December 1993 and 22 December 1993. The independent examination suggested that further tests were required, but the examiner believed a return to work would be appropriate unless further testing indicated to the contrary. When an MRI

was negative, the examiner determined that Clay should complete a functional capacity assessment ("FCA"). At first Clay refused to undergo a FCA. After Clay was told by her manager at P&G Paper that she might lose her disability benefits if she refused the FCA, she relented. But, Clay's results on the FCA were "self-limiting;" she refused to engage in most aspects of the test.

Clay remained on partial disability for the maximum period allowed under the Benefit Plan (52 weeks). Clay appealed her placement on partial disability; she maintained that she was totally disabled. Clay submitted a certificate from her physician that included the conclusory statement that she was totally disabled; it offered no supporting medical documentation for that conclusion. The Trustees of the Benefit Plan denied Clay's appeal of the partial disability determination.

While receiving partial disability payments, Clay applied (as required by the Benefits Plan) for Social Security benefits. Social Security benefits were denied on 31 October 1994. Clay requested reconsideration, but the denial was affirmed on reconsideration. Clay appealed the denial; she was awarded Social Security benefits on 27 September 1996 retroactive to 14 December 1993. With the Social Security decision now in her favor, Clay again appealed to the Benefits Plan in March 1997 to award her total disability status. The Benefit Plan denied her request; her appeal was not timely, the medical information submitted largely had been previously considered, new information submitted did not support a finding of total disability under the Benefits Plan, and the Social Security determination was not dispositive of qualification for purposes of the Benefit Plan.

As an initial matter, we must determine the standard of review applicable to the Benefit Plan's decision. Because it is undisputed that the Benefit Plan accords the Trustees discretion to interpret the Benefit Plan and to make eligibility and entitlement determinations, the arbitrary and capricious standard applies unless a conflict of interest is present to trigger a heightened arbitrary and capricious standard. *See Whateley v. CNA Ins. Companies*, 189 F.3d 1310, 1313 (11th Cir. 1999). Clay argues that the district court erred in not reviewing her claim under the more exacting standard applicable when a conflict is present; she failed, however, to present facts to the district court to raise a material issue of conflict. The district court, after reviewing all the evidence presented, found that the Trustees operated under no conflict of interest. We agree.

The Benefit Plan is employee funded and managed; by its terms, no benefits due under the Plan are obligations or liabilities of P&G Paper or its parent or sister companies.

Citing *Brown v. Blue Cross & Blue Shield of Ala.*, 898 F.2d 1556, 1566 (1990), Clay argues that the burden rests with the Trustee to show that its interpretation of the Benefit Plan and factual findings were not tainted by self-interest. But, this burden shifting comes into play only when a plan beneficiary demonstrates that a substantial conflict of interest exists. *See id.* ("we hold that when a plan beneficiary demonstrates a substantial conflict of interest on the part of the fiduciary responsible for benefits determinations, the burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest."). Beyond a conclusory allegation, Clay proffered no evidence that the Trustees operated with conflicted interests. While Clay

suggests that the acts of the Benefit Plan Trustees "indicate a deference" to P&G Paper officials, Clay failed to show the district court (and fails to show us) how this constituted a substantial conflict of interest when the Benefit Plan is no obligation of P&G Paper or related companies.

Clay also argues that the Benefit Plan's definitions of partial and total disability are ambiguous; she claims, without citation to authority, that the terms are "arbitrary and capricious per se." But even if ambiguity has been shown, it is undisputed that the Trustees were entrusted with discretion to interpret the Benefit Plan. Absent a conflict of interest, the arbitrary and capricious standard applies to our review of the Trustee's determinations; we will "reverse the denial of benefits only if the denial is completely unreasonable." *Brown*, 898 F.2d at 1564. Clay's claim that the Benefit Plan is "arbitrary and capricious per se" is without merit.

Clay contends that the district court erred because the Trustees' acts fail even an arbitrary and capricious standard. Again, our function "is to discern whether there was a reasonable basis for the decision, relying on the facts known to the administrator at the time the decision was made." *Buckley v. Metropolitan Life*, 115 F.3d 936, 941 (11th Cir. 1997). We conclude, as did the district court, that Clay raised no material issue on the reasonableness of the Trustees' determination of her claims given the medical evidence before them. While Clay makes much of the fact that Social Security benefits issued in her favor, the Trustees did not have the benefit of that determination – made on 27 September 1996 and finally submitted to the Trustees on 16 April 1997 – when the Trustees addressed Clay's claims in 1994 and 1995. And, the later

award of total disability benefits by the Social Security Administration is not dispositive of Clay's entitlement to total disability benefits under Benefits Plan. *See Paramore v. Delta Air lines, Inc.*, 129 F.3d 1446, 1452 n. 5 (11th Cir. 1997) (although court may consider award of Social Security benefits, such award is not dispositive of an ERISA plan claim, particularly given the deference owed a plan administrator's decision).

We have reviewed and find without merit Clay's additional argument that summary judgment was granted in error because (i) the Trustees violated ERISA procedure in handling her claims; and (ii) her termination wrongfully interfered with her ERISA rights.

AFFIRMED.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

FRANCES CLAY, Plaintiff, v. THE PROCTOR & GAMBLE PAPER PRODUCTS COMPANY, et al., Defendants.	CIVIL ACTION NO. 1:98-CV-1735A-JEC

ORDER

This case is presently before the Court on defendants' Motion for Summary Judgment [35]. The Court has reviewed the record and the arguments of the parties and, for the reasons set forth below, concludes that defendants' Motion for Summary Judgment [35] should be **GRANTED**.

BACKGROUND

Plaintiff brought this lawsuit alleging that defendants violated her rights under the Employment Retirement Income Security Act (hereinafter "ERISA"). Plaintiff is currently proceeding pro se. Plaintiff was employed by The Proctor & Gamble Paper Products Company (hereinafter "P&G") in Albany, Georgia beginning in September 1978. (Pl.'s Stmt. of Mat. Facts [38] at ¶ 1.) Shortly after her employment began, plaintiff chose to participate in the P&G Benefit Plan, an employee funded and managed disability plan. (*Id.* at ¶ 2.)

According to the P&G Benefit Plan, an employee is entitled to benefits if she meets the definition of partial disability or total disability. The Plan defines "partial disability" as

> a mental or physical condition resulting from an illness or injury because of which the Participant cannot perform regular duties but can perform other useful duties. Thus, a condition of Partial Disability does not necessarily prevent the Participant from performing useful tasks, utilizing public or private transportation, or taking part in social or business activities outside the home.

(Defs.' Stmt. of Mat. Facts [35] at Ex. 1 ("P&G Benefit Plan") at 3.) An employee who qualifies for partial disability is only entitled to 52 weeks of partial disability payments throughout that individual's participation in the employee benefits program. (*Id.* at 15.) Once an employee's 52 weeks of disability payments are completed, that employee is no longer entitled to partial disability payments for the duration of her employment with P&G. "Total disability" under the Plan is defined as

> a mental or physical condition resulting from an illness or injury which is generally considered totally disabling by the medical profession. Usually, Total Disability involves a condition of such severity as to require care in a hospital or restriction to the immediate confines of the home.

(*Id.* at 5.)

In addition, the Plan requires participants receiving partial disability to apply for "Social Security, State disability or other legislated or governmental benefits," as any receipt of outside benefits reduces the monthly partial disability benefit paid under the P&G Plan. (*Id.* at 11.)

The Plan was amended on March 26, 1996 to further explain the relationship between Social Security disability and total disability. The amended Plan states, "As a general rule, the Trustees will defer to Social Security's finding of Total Disability. However, the Trustees shall require a participant provide a copy of the SSA's record." (*Id.* at Ex. 37 at 2.)

The P&G Benefit Plan is administered by a Board of Trustees. (P&G Benefit Plan at 16.) Under the terms of the plan, the Trustees "have the discretionary authority to interpret the terms of this Plan and to determine the eligibility for an entitlement to Plan benefits in accordance with the terms of the Plan." (*Id.* at 18.) In addition the Plan provides,

> Any Participant receiving disability benefits shall, at the discretion of the Trustees, be required to submit to a physical examination by a physician designated by the Trustees and paid for from the Fund. A detailed report from such physician covering the then condition of the Participant shall be submitted to the Trustees. Based on this report, and in conjunction with the reports from the Participant's own physician and other facts applicable to the case, the trustees shall reach a decision with respect to payments of disability benefits under this Plan.

(*Id.* at 12.) A participant may appeal the denial of benefits or the termination of benefits within 60 days of the notice of denial of benefits or termination of benefits. (*Id.* at Ex. 37 at 2.) In the 1996 amendment to the plan, the Trustees further explained the relationship between partial disability, Social Security disability, and total disability. The Plan was amended to read,

> **II. Social Security Awarded after Partial Disability benefits have been terminated.** If the Social Security Award is received after the participant's partial Disability benefits have terminated (expiration of 52 weeks) and the appeal period has lapsed the closed disability case will not be reopened unless fraud is indicated. If the proper notices regarding the opportunities to appeal have not been provided to the participant, the award of Social Security may be retroactively reinstated to a Total Disability beginning with the date of the Social Security determination.
>
> * * *
>
> If the Plan is notified of a Social Security Award after the termination of [partial disability] benefits at 52 weeks and after the 60 day appeal period, the Plan will generally not be required to reinstate Total Disability benefits.

(*Id.* at Ex. 37 at 3.)

Plaintiff was involved in four automobile accidents between 1986 and 1993. Due to medical restrictions imposed by her physician, plaintiff was reassigned to a "storeroom window" position in 1987, which entailed less physical and mental strain than plaintiff's previous assignment. (Pl.'s Stmt. of Mat. Fact [38] at ¶ 8.) Plaintiff performed this job satisfactorily and without complaint until August 1993 when P&G reorganized the storeroom and eliminated the storeroom window position, a position shared by plaintiff and several other employees. (Defs.' Stmt. of Mat. Facts [35] at ¶ 9.) On August 19, 1993, a member of P&G's management met with plaintiff and asked her to provide medical information documenting her medical restrictions regarding the tasks that she could perform in order to permit management to reassign her to

a position consistent with her medical restrictions. (*Id.* at ¶ 9 & Ex. 6.) Initially, plaintiff failed to submit the requested medical information. (*Id.* at Exs. 6-8.)

In September, plaintiff met with Gail Hermann, P&G's Albany plant nurse, and discussed her medical restrictions with Ms. Hermann. (Pl.'s Stmt. of Mat. Facts [38] at ¶ 9.) At this meeting, plaintiff informed Ms. Hermann that she would provide medical documentation from her doctor after she visited him on October 4, 1993. (*Id.*) On October 5, 1993, plaintiff turned in a note from her doctor, indicating that plaintiff was unable to do a functional capacity assessment due to a previous cervical strain. (*Id.* at Ex. 5.) The doctor did not update plaintiff's medical restrictions, however, and plaintiff relied on a medical restriction form from an examination that took place on February 10, 1988. (*Id.* at Ex. 4.)

Because plaintiff had not turned in an updated medical restrictions form from her physician, P&G was unable to determine whether there were jobs available in the Albany plant that would meet her medical restriction. (Defs.' Stmt. of Mat. Facts [35] at Ex. 10.) Accordingly, P&G placed plaintiff on plant disability, allowing her paid leave until she met with her physician on December 21, 1993. (*Id.*) In a meeting on December 14, 1993, management informed plaintiff that if she was unable to return to work after December 21, 1993, she would have to apply for benefits under the P&G Benefit Plan. (*Id.*)

On December 21, 1993, plaintiff's physician filled out a medical restriction form. Her doctor indicated that she could return to work but with the following restrictions: no overhead lifting of more than 20 pounds, no carrying of more than 20 pounds, no lifting of more than 30 pounds,

no ladder climbing, and no full range of lifting. (Pl.'s Stmt. of Mat. Facts [38] at Ex. 8 ("December 21, 1993 Medical Restrictions").) Upon review of this document, the plant manager determined that there were no jobs available within the plant that met her particular medical restrictions. (*Id.* at ¶ 12.) After hearing this news, plaintiff returned to the doctor the next day and received another medical assessment. (*Id.*) The December 22, 1993 assessment indicated the plaintiff could climb metal stairs and increased plaintiff's lifting restrictions, assuming that she could use a metal cart to aid her in performing the lifting tasks. (*Id.* at Ex. 9 ("December 22, 1993 Medical Restrictions") at 1.) Management determined, however, that even under these revised set of restrictions, there were no jobs in the plant that plaintiff could safely perform. (Defs.' Stmt. of Mat. Facts [35] at ¶ 12.)

On January 25, 1994, the P&G Benefit Plan Trustees issued a letter granting plaintiff partial disability status retroactive to December 14, 1993. (*Id.* at Ex. 17 ("Trustee Benefits Determination") at 2.) Specifically, the Trustees wrote,

> Ms. Clay has been absent from work due to post traumatic headaches and cervical spine strain. Her doctor, Dr. John B. Baker, has indicated that Ms. Clay may return to work with the restrictions of no full range of reaching (including overhead), no ladder climbing, no lifting over 30 lbs., no overhead lifting of over 20 lbs. and no carrying over 20 lbs. As such, Ms. Clay is partially disabled as that term is defined in Article II, Section 11 of the Plan.

(*Id.*) Plaintiff began receiving disability payments for her partial disability immediately thereafter.

On January 12, 1994, Nurse Hermann called plaintiff and asked plaintiff to see Dr. Austin Colohan for an independent medical examination. (Pl.'s Stmt. of Mat. Facts [38] at 15.) Defendants assert that defendants asked her to submit to this additional evaluation "because of the ambivalence in her physician's evaluation of her capabilities between December 21, 1993 and December 22, 1993." (Defs.' Stmt. of Mat. Facts [35] at 15.) Dr. Colohan, a neurosurgeon, examined plaintiff and concluded, "I doubt that surgical pathology exists in this case, but have recommended that she have an MRI of both her cervical and lumbar regions since she is complaining of pain in both areas. At that point, I believe return to work would be appropriate.". (*Id.*) at Ex. 14 at 2.) After reviewing the MRI scans, Dr. Colohan wrote a letter to Nurse Hermann on February 4, 1994 stating that the MRI scans did not "show evidence of surgical pathology." (*Id.* at Ex. 18 at 1.) In the same letter, Dr. Colohan referred plaintiff to a doctor for treatment for chronic pain syndrome and determined that Ms. Clay was capable of completing a functional capacity assessment. (*Id.*)

On February 15, 1994, plaintiff's physician, Dr. Baker, sent a memorandum to the physical therapist who conducts functional capacity assessments for P&G which reads, "Mrs. Clay doesn't feel she can do the FCA because of neck pain, headaches and back aches. She feels it will cause her to have more pain in head and neck." (Defs.' Stmt. of Mat. Facts [35] at Ex. 24 at 11.) On March 9, 1994, plaintiff's department manager called plaintiff to discuss a functional capacity assessment to determine plaintiff's ability to return to work. (Pl.'s Stmt. of Mat. Facts [38] at ¶ 16.) In this discussion, the department manager explained to plaintiff that if she failed to take the

functional capacity assessment, her benefits might be suspended. (*Id.*)

On March 9, 1994, plaintiff appealed the Trustees' partial disability determination, asking the Trustees to award her total disability status. (Pl.'s Stmt. of Mat. Facts [38] at ¶ 17.) In this appeal, plaintiff explained her symptoms as follows:

> I am unable to work mentally and physically. I am suffering with constant severe complications with my head and spine. Some complications were mentioned earlier in this letter. Others are: severe headaches (these headaches affect my vision), intracranial pressure, dizziness (I fell to the floor unconscious two (2) time[s)], I get tired very quickly, I feel weak and tired most of the times [sic], shortness of breath, my memory is poor, my learning capacity and the ability to concentrate is very poor. Neck pain (aches all around neck at times), back pain (upper and lower). Also, I have numbness and pain in both hands and arms. The bottom line is, I am dying with brain damage.
>
> * * *
>
> P.S. I am not able to take the functional capacity test.

(Defs., Stmt. of Mat. Facts [35] at Ex. 20 at 2.) On April 12, 1994, the Trustees issued the following determination:

> With your appeal you provided copies of medical reports from 1986 and 1994. The Trustees do not believe that this additional medical information supports your claim for total disability benefits. The Trustees based their decision to change your status to partially disabled on the information contained in the physician's certificate signed by

> Dr. Baker on December 22, 1993. In this certificate Dr. Baker indicated you could return to full-time work as of December 14, 1993 with the restrictions of no full range reaching (including overhead), no ladder climbing, no lifting over 30 lbs., no overhead lifting over 20 lbs. and not carrying over 20 lbs. . . . The Trustees believe that this medical information is still pertinent and supports their determination to change your status from totally to partially disabled. In a handwritten note of February 15, 1994, Dr. Baker states that you do not feel that you can do a functional capacity assessment. An assessment was requested by the Trustees to keep them informed of your work restrictions. Without a recent assessment, the Trustees must rely on the information provided by Dr. Baker in December, 1993.

(*Id.* at Ex. 21 at 2.)

On May 12, 1994, the Trustees suspended plaintiff's partial disability benefits based on her continued refusal to participate in a functional capacity assessment. Indeed, the Trustees noted that

> [s]ections 6(d) and (e) [of the plan] provide that any Participant receiving disability benefits shall, at the discretion of the Trustees, be required to submit to a physical examination by an individual designated by the Trustees and paid for by the Fund. Additionally, the Trustees shall have the authority to require a change in medical treatment as may be recommended by the Medical Director of the Company or the Medical Director's designated representative, as a condition for making further payments of any disability benefits.

(*Id.* at Ex. 22 at 1.) In response to this letter, plaintiff, through her attorney William Eckhardt, advised P&G's personnel manager that she would participate in a functional capacity assessment on June 2, 1994 and June 7, 1994. (Pl.'s Stmt. of Mat. Facts [38] at ¶ 21.)

On June 2 and June 7, 1994, plaintiff attended the functional capacity assessment. The physical therapist who administered the test concluded that

> [t]he patient can stand and sit 9-12 hours per day. She refused the walking test. Lifting and carrying, pushing, pulling and lifting overhead were self-limited. Bending, stooping, climbing, balancing and reaching overhead were also self-limited. She refused to stoop. She can frequently kneel. She did not demonstrate a willingness to operate foot pedals repetitively. She can use her hands for repetitive actions, but her speed was slow.

(Defs.' Stmt. of Mat. Facts [35] at Ex. 27 at 00073.) After reviewing the results of the functional capacity assessment, William Moran, P&G's personnel manager, terminated plaintiff's employment on July 27, 1994. (*Id.* at Ex. 25 at 1.) Mr. Moran explained,

> According to the objective findings of the FCA you are unable to perform any work much beyond sitting or standing. The results of your FCA indicate that your primary limiting factor is your refusal to attempt to complete the tests. Specifically, for all the activities that you did participate in (except for sitting and standing) your results were reported as self-limiting. Considering comments that you made during the assessment it would appear that you are virtually unable to do anything beyond sitting or standing.

> Based on the results of the FCA, the restrictions imposed by your physician, and your statements regarding your limitations, we have no choice but to terminate your employment relationship. Regarding the FCA, the circumstances seem clear that you have chosen not to cooperate in our legitimate efforts to determine your physical limitations. . . . Further, you have made it clear that you are unable to perform physical work.

(*Id.*) A few days later, on July 1, 1994, Mr. Moran retracted the letter of termination, explaining that plaintiff was "currently on Partial Disability and as a participant of the Disability Benefit Plan [she] remain[s] an employee until benefits are exhausted or your employment with P&G is otherwise terminated." (*Id.* at Ex. 26 at 1.)

On July 5, 1994, the Trustees reinstated plaintiff's partial disability benefits retroactively to March 10, 1994. (*Id.* at Ex. 27 at 00067; Pl.'s Stmt. of Mat. Facts [38] at ¶ 25.) On August 3, 1994, defendants sent plaintiff a letter reminding plaintiff of her obligation to apply for Social Security disability benefits under the Plan and enclosing an application for Social Security disability. (*Id.* at Ex. 28.) On October 31, 1994, the Social Security Administration denied plaintiff's first application for disability benefits. (*Id.* at Ex. 29.)

In response to a letter from plaintiff's counsel written on November 11, 1994, P&G's associate general counsel, Steven Jemison, wrote to Mr. Eckhardt on December 1, 1994 explaining P&G's position regarding plaintiff's disability. (*Id.* at Ex. 31 at 00507.) In this letter, Mr. Jemison wrote,

> Regarding your request that Mrs. Clay's absence be converted to total disability status, that is a

> decision left up to the Trustees of the Procter & Gamble Disability Benefit Plan (Plan). The Plan is an employee funded and managed disability benefit plan. It is also a legal entity separate and apart from Procter & Gamble. Any determinations regarding eligibility for benefits are made by the Trustees of the Plan and not Procter & Gamble.[1] However, based on my understanding of the Plan, Mrs. Clay does not qualify for total disability benefits under the Plan because she is not totally incapacitated. She is able to perform some useful duties but simply cannot perform her regular duties at Proctor & Gamble.

(*Id.* at Ex. 31 at 00508-00509 (footnote in original).) In addition, Mr. Jemison wrote, "Mrs. Clay was encouraged to file for total disability benefits from the Social Security Administration. To our knowledge, she has not done so. It is my understanding that the Plan will defer to findings of total disability by the Social Security Administration." (*Id.* at Ex. 41 at 00509 n.3.)

Plaintiff's 52 weeks of partial disability benefits expired on December 11, 1994. (Pl.'s Stmt. of Mat. Facts [38] at ¶ 30.) On December 13, 1994, the Albany Plant Personnel Manager, Mr. Moran, sent plaintiff a separation notice along with a letter explaining that her medical restrictions are too severe to allow her to return to work. (*Id.* at ¶ 32; Def.s' Stmt. of Mat. Facts [35] at Ex. 32 at 1.) Accordingly, plaintiff was terminated on December 13, 1994.

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[1] Any questions regarding Mrs. Clay's status to receive benefits under the Plan should be directed to the Plan Trustees.

On December 15, 1994, plaintiff appealed the partial disability determination through her counsel, Mr. Eckhardt. (Pl.'s Stmt. of Mat. Facts [38] at ¶ 30.) In this appeal, the only medical documentation that plaintiff submitted was a physician's certificate dated December 2, 1994 from Dr. Baker. (*Id.*; Defs.' Stmt. of Mat. Facts [35] at Ex. 34 at 3.) On this physician's certificate, Dr. Baker indicated that plaintiff was "totally disabled" from December 14, 1993 and that it is "[i]ndefinite when [plaintiff] will return [sic] to work, if ever." (*Id.*) Indeed, plaintiff did not include any supporting medical documentation to explain why Dr. Baker came to the conclusion that she was totally disabled or why she could not return to work.

On January 10, 1995, the Trustees denied plaintiff's appeal. (Pl.'s Stmt. of Mat. Facts [38] at ¶ 31.) In the letter denying plaintiff's appeal, the Trustees reasoned,

> The information provided in your appeal included an updated Physician's Certificate stating that as of December 2, 1994, it is "indefinite when will return to work, if ever." The newly submitted information does not provide any additional supporting medical information. As set forth in the July 5, 1994, letter, the results from the Functional Capacity Assessment (FCA) performed June 2 and June 7, 1994, constitute the basis for the Trustees' determination of partial disability as that term is defined in the Disability Benefit Plan (Plan).
>
> Article II, section 11, of the Plan provides that "Partial Disability" means a mental or physical condition resulting from an illness or injury of which the Participant cannot perform regular duties but can perform other useful duties. Although Ms. Clay cannot perform her regular duties, she

> elected to not complete the FCA, which would have established any limitations of her disability. The Trustees requested that Ms. Clay supply information from her Physician identifying any physical limitations supporting a finding of total disability. Ms. Clay has declined to provide any such information. On the basis of these facts, the Trustees have determined that Ms. Clay is partially disabled.

(Defs.' Stmt. of Mat. Facts [35] at Ex. 35 at 00082.)

In December 1994, plaintiff requested reconsideration of the Social Security Administration's denial of her original application for Social Security disability benefits. (Pl.'s Stmt. of Mat. Facts [38] at ¶ 34; Defs.' Stmt. of Mat. Facts [35] at Ex. 36 at 1.) On April 5, 1995, the Social Security Administration denied plaintiff's appeal for reconsideration, finding that plaintiff was "still capable of performing some types of work." (Defs.' Stmt. of Mat. Facts [35] at Ex. 33 at 4.) On June 2, 1995, plaintiff filed a motion for a hearing on her application for Social Security disability. After a hearing on July 23, 1996, the Administrative Law Judge issued an order on September 27, 1996, finding that plaintiff "has been disabled since December 14, 1993" and was entitled to retroactive and future benefits under Social Security. (Pl.'s Stmt. of Mat. Facts [38] at Ex. 58 at 4.) On November 26, 1996, plaintiff received an award letter from the Social Security Administration explaining her benefits. (*Id.* at Ex. 59 at 2.)

On March 14, 1997, plaintiff wrote the Trustees, asking for them to award her total disability status based upon the Social Security Administration's award of disability benefits. (*Id.* at Ex. 59 at 1.) On April 11, 1997, the

Trustees rejected plaintiff's request. (Defs.' Stmt. of Mat. Facts [35] at Ex. 39 at 1.) The Trustees wrote,

> The Trustees have determined that no new medical information regarding your physical restrictions was included and have determined that your partial disability status under the Disability Benefit Plan (Plan) is proper. The basis for the total disability award by the Social Security Award [sic] may differ from the terms of the Plan. Your disability status has been determined to be Partially Disabled under the Disability Benefit Plan effective December 14, 1993. Your appeal is denied.

(*Id.*) On April 16, 1997, plaintiff wrote another letter to the Trustees, including the Administrative Law Judge's findings in her Social Security appeal. (*Id.* at Ex. 40.) The Trustees, in a ruling on April 25, 1997, responded,

> The Trustees have reviewed the new information provided in your letter of April 16, 1997. Although the summary of the medical information reviewed by the Social Security Administration appears to include new information, the summary of the medical information is insufficient. The Trustees are required to provide a period of 60 days, from the notice of a denial or termination of benefits, for a participant to provide any medical information in support of an appeal. The medical information provided to and summarized by the Social Security Administration in support of your claim for total disability should have [sic] provided to the Trustees for consideration during the period of review. The medical information should have been included in your timely appeal, dated December 15, 1994, of the termination of benefits. . . . The Trustees have determined that the basis for determination of Total Disability by

> the Social Security Administration is not based on the same criteria used to determine Total Disability under the Terms of the Plan. The Trustees have not timely received any medical information that supports a total disability determination under the terms of the Plan.

(*Id.* at Ex. 41 at 2.)

Plaintiff once again appealed this decision on May 27, 1994 by sending medical information to the Trustees. (Pl.'s Stmt. of Mat. Facts [38] at ¶ 39.) This information primarily consisted of medical records she had previously submitted to the Trustees dating back to 1986. (*Id.*) The Trustees issued their final determination on July 9, 1997 denying plaintiff total disability. (*Id.* at Ex. 43.) The Trustees explained,

> The Trustees have reviewed the new information provided in your letter of May 27, 1997. Although the appeal appears to include new information, the medical information was not provided timely. The Trustees are required to provide a period of 60 days, from the notice of a denial or termination of benefits, for a participant to provide any medical information in support of an appeal. The medical information provided in support of your recent appeal should have been provided to the Trustees for consideration during the period of review, from January 25, 1994, through December 11, 1994.

(*Id.* at Ex. 43 at 2.)

Plaintiff, through counsel, filed the instant lawsuit on June 19, 1998 alleging three causes of action under ERISA (Compl. [1].) Count One alleges that defendants breached their fiduciary duty to plaintiff by failing to follow the

terms of the Plan and by making false representations concerning the status of her claims for benefits. (*Id.* at ¶¶ 44-45.) Count Two contends that the Trustees' conduct was arbitrary and capricious and constituted a wrongful denial of benefits. (*Id.* at ¶¶ 48-51.) In addition, this Count alleges that defendants made decisions and determinations concerning plaintiff's disability status under a conflict of interest subjecting their actions to a de novo review by the Court. (*Id.* at ¶ 52.) Finally, Count Three asserts that Mr. Moran's decision to terminate plaintiff was a wrongful attempt to retaliate against plaintiff due to her lawful attempts to exercise her rights under ERISA. (*Id.* at ¶ 54.) After extensive settlement conference in front of Judge Moye,[2] plaintiff's attorney withdrew from his representation of plaintiff. (Order [24] at 1.) Currently, plaintiff is proceeding pro se.

This case is presently before the Court on defendants' motion for summary judgment filed on October 12, 1999. (Defs.' Mot. for Summ. J. [35] at 1.) The Court ordered plaintiff to respond by November 1, 1999, and on November 1, 1999 plaintiff responded to the motion in a brief, four-page response. (Pl.'s Resp. to Defs.' Mot. for Summ. J. [38] at 1.)

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[2] Judge Moye recused himself from consideration of this case on June 22, 1999 due to his participation "in extensive settlement discussions in this non-jury case." (Order [24] at 1.) The case was reassigned to this Court.

DISCUSSION

I. Summary Judgment Standard

Summary Judgment is not properly viewed as a device that the trial court may, in its discretion, implement in lieu of a trial on the merits. Instead, Rule 56 of the Federal Rules of Civil Procedure *mandates* the entry of summary judgment against a party who fails to make a showing sufficient to establish the existence of *every* element essential to that party's case on which that party will bear the burden of proof at trial. *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). In such a situation, there can be no genuine issue as to any material fact, as a complete failure of proof concerning an essential element of the nonmoving party's case necessarily renders all other facts immaterial. *Id.* at 322-23.

The movant bears the initial responsibility of asserting the basis for his motion. *Id.* at 323; *Apcoa, Inc. v. Fidelity Nat'l Bank*, 906 F.2d 610, 611 (11th Cir. 1990). However, the movant is not required to negate his opponent's claim. The movant may discharge his burden by merely "'showing' – that is, pointing out to the district court – that there is an absence of evidence to support the nonmoving party's case." *Celotex*, 477 U.S. at 325. After the movant has carried his burden, the nonmoving party is then required to "go beyond the pleadings" and present competent evidence[3] designating "'specific facts showing there is a genuine issue for trial.'" *Id.* at 324 (quoting FED.

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[3] The nonmoving party may meet its burden through affidavit and deposition testimony, answers to interrogatories, and the like. *Celotex*, 477 U.S. at 324.

R. Civ. P. 56(e)). While the court is to view all evidence and factual inferences in a light most favorable to the nonmoving party, *Samples v. City of Atlanta*, 846 F.2d 1328, 1330 (11th Cir. 1988), "the mere existence of *some* alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment; the requirement is that there be no *genuine issue of material fact*." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986).

A fact is material when it is identified as such by the controlling substantive law. *Id.* at 248. An issue is genuine when the evidence is such that a reasonable jury could return a verdict for the nonmovant. *Id.* at 249-50. The nonmovant "must do more than simply show that there is some metaphysical doubt as to the material facts. . . . Where the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party, there is no 'genuine issue for trial.'" *Matsushita Electric Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586-87 (1986) (citations omitted). An issue is not genuine if it is unsupported by evidence, or if it is created by evidence that is "merely colorable" or is "not significantly probative." *Anderson*, 477 U.S. at 249-50. Thus, to survive a motion for summary judgment, the nonmoving party must come forward with specific evidence of every element material to that party's case so as to create a genuine issue for trial.

II. Plaintiff's ERISA Claims

Plaintiff alleges three different claims under ERISA. The Court will address each claim.

A. *Plaintiff's Wrongful Denial of Benefits Claim*

Plaintiff claims that defendants unlawfully denied her request for total disability in violation of 29 U.S.C. § 1132(a)(1)(B). A denial of ERISA benefits challenged under 29 U.S.C. § 1132(a)(1)(B) is reviewed under one of three standards of review as dictated by the Supreme Court in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). As the Eleventh Circuit has recently clarified, the three standards of review are:

> (1) de novo, applicable where the plan administrator is not afforded discretion, (2) arbitrary and capricious where the plan grants the administrator discretion, and (3) heightened arbitrary and capricious where there is a conflict of interest.

Paramore v. Delta Air Lines, Inc., 129 F.3d 1446, 1449 (11th Cir. 1997).

Defendants contend that the P&G Benefit Plan grants discretion to the Board of Trustees to interpret the Plan and to determine eligibility for benefits. Accordingly, defendants assert that this Court must review the Trustees' denial of total disability benefits under the arbitrary and capricious standard. Plaintiff does not dispute that the Plan grants the Trustees' discretion to interpret the Plan and determine eligibility.

Indeed, the Plan clearly vests discretion on the Trustees to interpret the plan. The Plan states, "The Trustees have the discretionary authority to interpret the terms of this Plan and to determine the eligibility for and entitlement to Plan benefits in accordance with terms of the Plan." (P&G Benefit Plan at 18.) Clearly, the Plan document affords the Board of Trustees' discretion to construe

the plan's terms and to determine a participant's eligibility for benefits. *See Paramore*, 129 F.3d at 1450. Accordingly, the Court will review the Trustees' decision to deny total disability to plaintiff under the arbitrary and capricious standard.[4]

The Court must begin its review of the Trustees' initial decision to grant partial disability to plaintiff on January 25, 1994. At this time, the only medical information available to the Trustees were two evaluations from plaintiff's doctor regarding medical restrictions. Both the December 21 and 22, 1993 assessments from plaintiff's doctor indicated that plaintiff could return to work with some restrictions. The first restriction limited plaintiff's ability to lift, carry, and lift objects overhead and restricted plaintiff's ability to climb ladders. Likewise, the second restriction only increased the lifting restrictions, assuming plaintiff could use a metal cart, and allowed plaintiff to climb metal stairs. It is clear from these restrictions that plaintiff was still able to work and was not totally disabled under the terms of the plan. As discussed *supra*, "total disability" under the Plan is defined as "a mental or physical condition resulting from an illness or injury which is generally considered totally disabling by

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[4] In her complaint, plaintiff alleges that "[t]he conflict of interest under which Defendants made decisions and determinations concerning Plaintiff rendered such determinations suspect and subject to de novo review by this Court." (Compl. [1] at ¶ 52.) Plaintiff does not, however, back up this conclusory allegation with any evidence that the Trustees acted with a conflict of interest. Indeed, the Court has reviewed the evidence in this case and finds that no such conflict existed. Accordingly, the Court will not review the Trustees' decision to deny benefits under a heightened arbitrary and capricious standard.

the medical profession. Usually, Total Disability involves a condition of such severity as to require care in a hospital or restriction to the immediate confines of the home." (P&G Benefit Plan at 5.) Clearly, the Trustees' decision on January 25, 1994 to grant only partial disability was not arbitrary and capricious, as plaintiff's own doctor cleared her to return to work, conclusively establishing that plaintiff's condition was not "totally disabling."

Plaintiff appealed this determination on March 9, 1994. The Trustees once again denied plaintiff total disability, relying on plaintiff's doctor's work restrictions, which plaintiff had not updated with any new medical information since the original denial of total disability by the Trustees in January, and additional medical information collected by the Trustees. This information included the results of an examination performed by Dr. Colohan, a neurosurgeon, who examined plaintiff and concluded that plaintiff could return to work. In addition, Dr. Colohan performed two MRIs on plaintiff, both indicating no surgical pathology, and determined that plaintiff could take a functional capacity assessment to aid in the Trustees' determination of plaintiff's disability status. Plaintiff, however, refused to take the functional capacity assessment, obtaining a letter from her doctor which read, "Mrs. Clay doesn't feel she can do an FCA." Notably, this note did not include any medical documentation of plaintiff's medical status and did not contain the doctor's opinion on whether she could perform a functional capacity evaluation.

Considering this information, the Trustees' decision to deny total disability was not arbitrary and capricious. The Trustees had two doctors, plaintiff's doctor and the independent neurosurgeon, who both determined that plaintiff

could return to work. Moreover, plaintiff did not provide any new information that supported her claim for total disability. Rather, plaintiff simply relied on old information dating back to 1986 and her doctor's December 1993 evaluations. From the information provided to the Trustees, the board properly found that plaintiff was not totally disabled because she could return to work in some capacity, albeit with limitations.

When plaintiff's partial disability payments ceased in December 1994 due to the fact that plaintiff had accrued the maximum allowable period of partial disability, she appealed the Trustees' decision to deny her total disability under the plan. In this appeal, plaintiff only submitted one new document to support her claim for total disability. This document was a physician's certificate from her doctor, indicating that plaintiff was "totally disabled" and predicting that it was "[i]ndefinite when [plaintiff] willreturn [sic] to work, if ever." (Defs.' Stmt. of Mat. Facts [35] at Ex. 34 and 3.) Although the physician made the bald assertions that plaintiff was totally disabled and unable to return to work, the physician did not, however, include any explanation or medical documentation to support his conclusion.

The Trustees determined that plaintiff had not submitted sufficient medical information to support her claim for total disability. Indeed, plaintiff's claim for total disability contradicted the other medical information included in her file, including a 1994 functional capacity assessment that plaintiff chose not to complete and two previous doctor's determinations that plaintiff could return to work. The Court cannot find that the Trustees' determination was arbitrary and capricious, especially in light of plaintiff's consistent refusal to complete a functional capacity

assessment to aid in the Trustees' determinations of her disability status and the clear medical information in her file that supported their conclusion that plaintiff could still perform useful duties.

In March 1997, over two years after plaintiff's partial disability benefits were terminated, plaintiff wrote the Trustees asking for them to award her total disability status in light of the Administrative Law Judge's determination in September 1996 that she was entitled to Social Security disability. The Trustees denied plaintiff's request due to the fact that plaintiff, once again, failed to present any medical information to support her claim that she was totally disabled. Subsequently, in April 1997, plaintiff again appealed, including the Administrative Law Judge's opinion granting her Social Security disability. The Trustees denied her request, determining that plaintiff's appeal was not timely, as she was required to file the appeal, including the medical information, within sixty days of the termination of benefits. The Trustees also noted that the medical information provided to the Social Security Administration consisted of information that the Trustees had already reviewed in making their original determination and consisted of information that plaintiff could have provided during her original sixty-day appeal period.

The Court finds that the Trustees' determination was reasonable. Pursuant to the explicit terms of the policy, a participant who receives an adverse decision from the Board of Trustees has sixty days to appeal either from the date of an adverse decision or from the date of the termination of benefits. (Defs.' Stmt. of Mat. Facts [35] at Ex. 37 at 2.) It is undisputed that plaintiff's final appeals in the

instant case did not occur until two years after her benefits were terminated. Moreover, the P&G Plan was amended in 1996, prior to plaintiff's successful application for Social Security disability, to explain the relationship between Social Security disability, partial disability, and total disability. The Plan expressly contemplated plaintiff's situation, explaining, "If the Plan is notified of Social Security Award after the termination of [partial disability] benefits at 52 weeks and after the 60 day appeal period, the Plan will generally not be required to reinstate Total Disability benefits." (*Id.* at Ex. 37 at 3.) Based on the words of the amended plan, the Trustees were not required to grant plaintiff total disability status, and their decision to deny plaintiff's appeal was not arbitrary and capricious.

Accordingly, plaintiff's wrongful denial of benefits claim under 29 U.S.C. § 1132(a)(1)(B) is untenable, and defendants' motion for summary judgment as to this claim is **GRANTED**.

B. *Plaintiff's Breach of Fiduciary Duty Claim*

In her complaint, plaintiff alleges that defendants breached their fiduciary duty to plaintiff in two ways. First, she claims that Mr. Jemison, P&G's associate general counsel, made a binding representation to plaintiff when he wrote in his letter to plaintiff's attorney on December 1, 1994 that "[i]t is my understanding that the Plan will defer to findings of total disability by the Social Security Administration." (*See* Defs.' Stmt. of Mat. Facts [35] at Ex. 31 at 00509 n.3.) Plaintiff asserts that the Trustees violated their fiduciary duty by failing to abide by Mr. Jemison's statement when they denied plaintiff

total disability status in 1997 after plaintiff had been awarded Social Security disability benefits. (Compl. [1] at ¶ 45.)

It is clear from a reading of Mr. Jemison's letter that he did not intend the statement to be binding on the company or on the Trustees. Indeed, Mr. Jemison explained to plaintiff and her attorney, "Regarding your request that Mrs. Clay's absence be converted to total disability status, that is a decision left up to the Trustees of the Procter & Gamble Disability Benefit Plan (Plan). The Plan is an employee funded and managed disability benefit plan. It is also a legal entity separate and apart from Procter & Gamble. Any determinations regarding eligibility for benefits are made by the Trustees of the Plan and not Procter & Gamble." (Defs.' Stmt of Mat. Facts [35] at Ex. 31 at 00508-00509.) Although Mr. Jemison indicated his belief that the Trustees would likely defer to the Social Security's determination of total disability, plaintiff could not have reasonably believed that he was speaking on behalf of the P&G Benefit Plan or its Trustees. Accordingly, the Trustees did not violate their fiduciary duties by failing to award plaintiff total disability two years after plaintiff's partial disability status was terminated.[5]

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[5] In the event that plaintiff is attempting to allege an equitable estoppel claim, plaintiff has failed to point to any language in the Plan that is ambiguous that Mr. Jemison was attempting to interpret when he made the representation to plaintiff. *See Novak v. Irwin Yacht & Marine Corp.*, 986 F.2d 468 (11th Cir. 1993). Indeed, Mr. Jemison, after explaining to plaintiff and her attorney that he could not speak for the plan, explained his understanding pursuant to the explicit terms of the Plan that a participant's receipt of Social Security disability is generally sufficient to render that individual totally disabled under the Plan. Mr.

(Continued on following page)

Plaintiff's second fiduciary duty claim is likewise without merit. Plaintiff claims that the Trustees violated their fiduciary duties when they "did not follow ERISA or Plan procedures concerning the benefits claim process; they encouraged Ms. Clay to appeal their determination upon obtaining additional information but then refused to consider such information, when available, on grounds of timeliness; and they caused Ms. Clay to rely on the explicit representation that her claim was still being considered." (Compl. [1] at ¶ 42.) The Court finds that this claim duplicates her wrongful termination claims discussed above. *See Harrison v. Digital Health Plan*, 183 F.3d 1235, 1237 n.1 (11th Cir. 1999). Moreover, it is clear from a review of the evidence presented at the summary judgment stage of this proceeding that, other than the summary allegations contained in her complaint and in her terse response to defendants' motion for summary judgment, the plaintiff has not presented any evidence to support her claim that the Trustees failed to thoroughly review and consider plaintiff's total disability claims each time she applied and appealed for benefits under the Plan.

Accordingly, plaintiff's breach of fiduciary duty claims must be dismissed, and defendants' motions for summary judgment are **GRANTED** as to this claim.

Jemison did not promise plaintiff that she would receive total disability benefits but merely restated the express terms of the plan. (*See* Defs.' Stmt. of Mat. Facts [35] at Ex. 37 ("1996 Amendment") at 2.)

C. *Plaintiff's Wrongful Termination Claim*

Section 510 of ERISA makes it "unlawful for any person to discharge . . . a participant or beneficiary . . . for the purpose of interfering with the attainment of any right to which such participant may become entitled." 29 U.S.C. § 1140. In order to establish a *prima facie* case for a discriminatory discharge under this statutory provision, a plaintiff must demonstrate:

> (1) that he is entitled to ERISA's protection, (2) was qualified for the position, and (3) was discharged under circumstances that give rise to an inference of discrimination. . . . To satisfy the last element the plaintiff does not have to prove discriminatory intent but must introduce evidence that suggests interference with ERISA rights was a motivating factor. . . . The plaintiff, however, cannot establish a prima facie case merely by showing that, as a result of the termination, he was deprived of the opportunity to accrue more benefits. . . . Moreover, measures designed to reduce costs in general that also result in an incidental reduction in benefit expenses do not suggest discriminatory intent. . . . Instead the employee must introduce evidence suggesting that the employer's decision was directed at ERISA rights in particular.

Gitlitz v. Compagnie Nationale Air France, 129 F.3d 554, 559 (11th Cir. 1997) (quoting *Clark v. Coats & Clark*, 990 F.2d 1217, 1223-24 (11th Cir. 1993)).

In the instant case, plaintiff is unable to satisfy her burden of demonstrating a prima facie case of discrimination, as she cannot show that she was qualified for any position within defendants' plant. Indeed, plaintiff alleges throughout this litigation that she was unable to perform

any work for defendants, as she claims that she was totally disabled.

Moreover, plaintiff's wrongful termination claim fails because she cannot demonstrate that defendants' decision to terminate her was directed at her ERISA rights in particular. *See Gitlitz*, 129 F.3d at 559. Plaintiff has not attempted to show that she was terminated to avoid paying her total disability payments. Indeed, as the evidence in this case shows, plaintiff was entitled to pursue her quest for total disability, and her termination did not effect this quest. Without such proof, plaintiff is unable to prevail on her wrongful termination claim.

Accordingly, plaintiff's wrongful termination claim under § 510 of ERISA is dismissed, and defendants' motion for summary judgment as to this claim is **GRANTED**.

CONCLUSION

For the foregoing reasons, defendants' Motion for Summary Judgment [35] is **GRANTED**.

SO ORDERED, this 16 day of February, 2000.

/s/ Julie Carnes
JULIE E. CARNES
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

No. 00-11364-CC

(Filed Sep. 4, 2002)

FRANCES CLAY,

Plaintiff-Appellant,

versus

PROCTER & GAMBLE PAPER PRODUCTS COMPANY,
PROCTER & GAMBLE COMPANY, and Certain Subsidiaries,
PROCTER & GAMBLE DISABILITY BENEFIT PLAN,
PROCTER & GAMBLE BENEFIT PLAN TRUST,

Defendants-Appellees.

On Appeal from the United States District Court for the Northern District of Georgia

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ON PETITION(S) FOR REHEARING AND PETITION(S) FOR REHEARING EN BANC

(Opinion ___, 11th Cir., 19___, ___F.2d___).

Before: EDMONDSON, Chief Judge, BLACK and MARCUS, Circuit Judges.

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35,

Federal Rules of appellate Procedure), the Petition(s) for Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:

/s/ J.L. Edmondson
CHIEF JUDGE